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IN THE
Supreme Court of the United States

DON STENBERG, Attorney General
of the State of Nebraska, *et al.*,
Petitioners,
v.
LEROY CARHART, M.D.,
Respondent.

**On Writ of Certiorari to the
United States Court of Appeals
for the Eighth Circuit**

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, NATIONAL ABORTION FEDERATION, PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH, AND AMERICAN NURSES ASSOCIATION IN SUPPORT OF RESPONDENT

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Women's Association ("AMWA"), the National Abortion Federation ("NAF"), Physicians for Reproductive Choice and Health ("PRCH"), and the American Nurses Association ("ANA") submit this brief *amici curiae* in support of Respondent.[1]

ACOG, a non-profit educational and professional organization founded in 1951, is the leading professional association of physicians who specialize in the health care of women. Its more than 40,000 members represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States, and it is the body representing the vast majority of physicians affected by Nebraska's ban on "partial-birth abortion" (the "Act"). Its members, whatever their beliefs about abortion, share an interest in opposing laws that interfere with a physician's ability to exercise his or her best medical judgment to determine the appropriate care for each patient, and they believe that physicians must be able to use new techniques or vary recognized techniques in order to advance the development of safe, effective medical procedures. ACOG has appeared as *amicus* in seven other cases involving laws similar to the Act.

AMWA is a national organization of 10,000 women physicians and physicians-in-training, dedicated to promoting women's health and fostering the woman physician. Founded in 1915, AMWA has physician chapters in 35 states, including Nebraska, and student chapters in nearly all of the nation's 144 medical schools. AMWA

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored any portion of this brief, and no person other than *amici* and their counsel made any monetary contribution to the preparation or submission of this brief. Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

strongly opposes legislation banning any method of abortion or other interference with decision-making appropriately left to the woman and her physician.

NAF, a private, non-profit organization founded in 1977, is the professional association of abortion providers in the United States and Canada. NAF's mission is to promote and enhance the quality of abortion services, ensuring that abortion remains safe, legal, and accessible. NAF publishes clinical practice guidelines for abortion, publishes a leading textbook on abortion practice, and sponsors accredited continuing medical education programs for abortion providers. Its members include over 350 non-profit and private clinics, women's health centers, Planned Parenthood facilities and private physicians' offices in 46 states. NAF's members provide over half of the abortions performed in the United States each year and will thus be directly affected by the Act and similar laws in other states.

PRCH is a national, physician-led, non-profit organization founded in 1992. PRCH represents more than 3,500 physicians of various disciplines, and non-physician supporters. PRCH's mission is to enable concerned physicians to take a more active and visible role in support of voluntary universal reproductive healthcare. PRCH is committed to ensuring that all people have the knowledge, equal access to quality services, and freedom of choice to make their own reproductive health care decisions.

ANA is the only full-service professional organization representing the nation's 2.6 million registered nurses through its 53 constituent associations. ANA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, and projecting a positive and realistic view of nursing. ANA is committed to ensuring the ready availability and accessibility of health

care services and has long supported freedom of choice and equitable access for all women to basic health services, including reproductive health care.

STATEMENT OF MEDICAL FACTS

The physician's main goal in performing any abortion is to terminate the pregnancy by the method safest for the woman.

1. First-Trimester Abortions [2]

The overwhelming majority of abortions in Nebraska —and nationwide—are performed in the first trimester of pregnancy.[3] In 1996, almost 90% of abortions occurred before 13 weeks LMP.[4] Virtually all first-trimester abortions are performed using a method known as vacuum aspiration (sometimes called suction curettage).[5] Vacuum aspiration is the safest surgical abortion procedure prac-

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[2] This discussion does not include early "medical" abortions—those performed by administering drugs (such as RU 486) to a pregnant woman to induce a miscarriage—which would not be banned by the Act. However, in the approximately 5% of cases in which a medical abortion fails, the pregnant woman would have to undergo a vacuum aspiration procedure.

[3] *See, e.g.*, Lisa M. Koonin et al., *Abortion Surveillance—United States, 1996, in CDC Surveillance Summaries*, 48 MORBIDITY AND MORTALITY WEEKLY REPORT (No. SS-4) 1, 25-26, 29 (Tables 6 & 8) (CDC, July 30, 1999).

[4] *Id.* Measuring the pregnancy in terms of "LMP" dates the length of the pregnancy from the first day of the woman's last menstrual period before she became pregnant. Fetal age measured by LMP is on average two weeks greater than if measured from the estimated date of conception.

[5] Koonin at 6; *see* A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION 107, 108 (Maureen Paul, et al. eds., 1999) ("CLINICIAN'S GUIDE"); Phillip G. Stubblefield, *First and Second Trimester Abortion, in* GYNECOLOGIC, OBSTETRIC, AND RELATED SURGERY 1033, 1033 (David H. Nichols & Daniel L. Clarke-Pearson eds., 2d ed. 2000).

ticed today.[6] It is generally used for abortions up to 14 weeks LMP.[7]

In a vacuum aspiration procedure, the physician dilates the cervix and inserts a small tube called a cannula through the vagina and cervix and into the uterus. Once the cannula is in the uterus, the physician creates negative pressure and delivers the products of conception. A single pass or several passes of the cannula through the uterus may be required before all the products of conception have been removed. The embryo or fetus may come through the cannula intact or disarticulated, and a portion of the fetus may enter the vagina while the fetus is still alive. Later in the first trimester, if the physician cannot complete the procedure with the cannula, rigid curettage or forceps may be necessary to remove the products of conception completely.[8]

2. Post-First-Trimester Abortions

In the second trimester of pregnancy (roughly 13-26 weeks LMP), when vacuum aspiration is no longer effective, dilatation and evacuation ("D&E"), and induction to a much lesser extent, are the most commonly used abortion procedures.[9]

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6 *See* CLINICIAN'S GUIDE at 108-09; Herschel W. Lawson et al., *Abortion Mortality, United States, 1972 Through 1987*, 171 AM. J. OBSTETRICS & GYNECOLOGY 1365, 1367-68 (Tables II & III) (1994); Willard Cates, Jr. & David A. Grimes, *Morbidity and Mortality of Abortion in the United States, in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 155, 161 (Jane E. Hodgson ed., 1981).

7 *See generally* Pak Chung Ho, *Termination of Pregnancy Between 9 and 14 Weeks, in* MODERN METHODS OF INDUCING ABORTION 54, 56-57 (1995); CLINICIAN'S GUIDE at 109.

8 *See* PHILIP D. DARNEY ET AL., PROTOCOLS FOR OFFICE GYNECOLOGICAL SURGERY 169-74 (1996); CLINICIAN'S GUIDE at 111-12; Stubblefield at 1035-37.

9 ACOG, Technical Bulletin 109, *Methods of Midtrimester Abortion* (1987); *see generally* Stubblefield at 1042-45; CLINICIAN'S GUIDE at 123.

Dilatation and Evacuation. D&E now accounts for over 90% of post-first-trimester abortions performed in the United States. *See* Koonin at 41 (Table 18). Although every physician's technique varies somewhat, in general the physician begins by dilating the cervix with laminaria, which slowly expand by absorbing moisture from the woman's cervix and thus increase the circumference of its opening (or os). Laminaria are inserted hours to days prior to the evacuation portion of the procedure. The amount of time required for adequate dilatation varies based on a number of factors including the gestational age of the fetus and the number of prior vaginal deliveries.

After the cervix is sufficiently dilated, the patient returns to the physician to undergo the evacuation procedure, which lasts 10 to 30 minutes.[10] The physician begins by rupturing the membranes and suctioning out the amniotic fluid. Then a clamp or forceps is inserted through the dilated cervix. Using the instrument, the physician reaches into the uterus, grasps the fetus and attempts extraction. The physician does this by pulling the fetal part he or she has grasped in the instrument through the cervical os and into the vagina. At this point the fetus is usually intact. Often, especially earlier in the second trimester, disarticulation occurs after a fetal part has been brought into the vagina—as it does in Dr. Carhart's practice, *Carhart v. Stenberg*, 11 F. Supp. 2d 1099, 1103 (D. Neb. 1998), *aff'd*, 192 F.3d 1142 (8th Cir. 1999)—due to the counterpressure exerted as the rest of the fetus lodges against the uterine wall. Continuing disarticulation of fetal parts eventually kills the fetus. In some D&Es, little or no disarticulation occurs, and the physician removes the fetus relatively intact.

Especially later in the second trimester, the head of the fetus, its largest part, will generally be too big to fit

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10 For a more extensive description of the evacuation process, *see generally* EUGENE GLICK, SURGICAL ABORTION 48-57 (1998); DARNEY at 198-207; Stubblefield at 1042-44; CLINICIAN'S GUIDE at 127-36.

through the cervix because cervical dilatation is only about 20% of that achieved at term. In that case, the skull must be compressed to allow it to pass through the cervix. There are several ways to accomplish this, including using forceps or evacuating the contents with suction.

Intact D&E. Later in the second trimester, some physicians perform D&Es in which the fetus is delivered intact (known as "intact D&E"). In one variant, the physician brings the fetus through the cervix intact in a breech (feet- or buttocks-first) position up to the head and, if the head lodges in the uterus, collapses it to complete extraction. ACOG has referred to this procedure as intact dilatation and extraction ("intact D&X" or "D&X").[11] In another variant of intact D&E, the physician begins by collapsing the skull of a fetus that is presenting head-down and then delivers the fetus intact. Regardless of the presentation, such intact extractions constitute intact D&E procedures. Intact D&E, including D&X, is a minor—and often safer—variant of the "traditional" non-intact D&E.[12] It makes no medical difference whether any portion of the fetus is delivered before fetal demise.[13] An intact D&X may be the best or most appropriate procedure for a particular patient in a par-

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11 ACOG's description of this procedure is set forth in its *Statement on Intact Dilatation and Extraction* (Jan. 12, 1997) (*"ACOG Statement"*). ACOG attempted to define the procedure that was being discussed at the time in the highly charged political debate, congressional testimony, and in other publications. There is no medical or medical-ethical reason to distinguish among any of the variants of D&E.

12 *See generally* National Abortion Federation, *Second Trimester Abortion From Every Angle: Presentations, Bibliography & Related Materials* (1992) (*"NAF Bibliography"*); Stubblefield at 1043 (describing intact D&E as a "variation of D&E" and referring to "[t]he breech extraction variation of intact D&E").

13 *See* CLINICIAN'S GUIDE at 136-37; Stubblefield at 1043; Janet E. Gans Epner et al., *Late-term Abortion*, 280 JAMA 724, 726 (Aug. 26, 1998).

ticular circumstance.[14] Only the physician, in consultation with the patient and based on her circumstances, can make this decision.

Induction. Induction, or induced preterm labor, consists of "stimulating uterine contractions before the spontaneous onset of labor." ACOG, Practice Bulletin No. 10, *Induction of Labor* 1 (Nov. 1999) (*"Induction of Labor"*). This method accounts for only about 5% of post-first-trimester procedures nationally. Koonin at 41 (Table 18). The physician uses one of several substances and methods to induce labor, for example, prostaglandin in the form of vaginal suppositories or intramuscular injections; oxytocin as an intravenous injection; or some combination of saline, urea, and prostaglandin injected into the amniotic cavity. Although some of these substances may cause the death of the fetus, others do not. Rather, they initiate labor, which can last more than 24 hours and which usually, but not always, causes the death of a nonviable fetus.[15] In some cases in which the induction results in a breech delivery, the fetal skull may be too large to fit through the partially dilated cervix, in which case the physician generally collapses the skull (sometimes while the fetus still has a heartbeat) in order to complete the delivery. In other inductions, the umbilical cord may become entangled after the (still living)

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14 *See* Part II.B.1, *infra*. At least five federal courts have found that this procedure may be the safest one for women in the later part of the second trimester. *See Planned Parenthood v. Doyle*, 162 F.3d 463, 467-68 (7th Cir. 1998); *Carhart*, 11 F. Supp. 2d at 1107-08; *Hope Clinic v. Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998), *rev'd on other grounds*, 195 F.3d 857 (7th Cir. 1999); *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995), *aff'd on other grounds*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 1347 (1998); *Evans v. Kelley*, 977 F. Supp. 1296, 1316 (E.D. Mich. 1997).

15 F. GARY CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 599-600 (20th ed. 1997); *Induction of Labor* at 1; JAMES R. WOODS, JR. & JENNIFER L. ESPOSITO, PREGNANCY LOSS 59-61 (1987); CLINICIAN'S GUIDE at 139, 143 (Table 11-2).

fetus has been delivered into the vagina, requiring the physician to cut the cord (which kills the fetus) to complete the delivery.

Because induction requires around-the-clock medical attention, inductions take place in hospitals or hospital-level settings, thus greatly increasing expense and limiting accessibility. *See* Stubblefield at 1046; CLINICIAN'S GUIDE at 125. Some medical authorities indicate that induction often is unsuccessful prior to approximately 16 weeks LMP because the uterus is less responsive to the inducing agents. *See* PREGNANCY LOSS at 59; *Methods of Midtrimester Abortion* at 3; GLICK at 46-48. In the case of an incomplete or unsuccessful induction, a subsequent surgical abortion procedure is necessary. CLINICIAN'S GUIDE at 125. Induction poses risks to some women and may be absolutely contraindicated for others.[16]

Hysterotomy and Hysterectomy. Hysterotomy—a preterm cesarean section—is a radical procedure to terminate a pregnancy, WILLIAMS OBSTETRICS at 684-85; *Methods of Midtrimester Abortion* at 2, that was deemed "out of date" as an abortion technique fully 19 years ago.[17] Hysterotomy, a major surgical procedure, has all the risks of such surgery and is considerably riskier than either induction or D&E. *See, e.g.*, Gans Epner at 727 & Table

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16 For example, prostaglandins are contraindicated in patients with sepsis (blood infection), hypertension (high blood pressure), coronary artery disease, and, in some cases, asthma. CLINICIAN'S GUIDE at 125. Women with certain heart defects, such as defective heart valve, may not survive prolonged labor. *Id.* Inductions are also contraindicated for women who have had a previous hysterotomy or cesarean section with classical (vertical) scar because it can lead to uterine rupture, hemorrhage, and even death. *See* P. Boulout et al., *Late Vaginal Induced Abortion after a Previous Cesarean Birth: Potential for Uterine Rupture*, 36 GYNECOLOGIC & OBSTETRIC INVESTIGATION 87, 88 (1993); *Methods of Midtrimester Abortion* at 2.

17 P. Diggory, *Hysterotomy and Hysterectomy as Abortion Techniques, in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 317, 331 (Jane E. Hodgson ed., 1981).

4. It is significantly more dangerous than a cesarean section done at term, because the uterine wall is thicker and tends to bleed more. It may also cause uterine rupture in subsequent pregnancies and may require the woman to have any subsequent delivery by cesarean section. Diggory at 317.

Hysterectomy, or the removal of the uterus, is not an appropriate method of abortion under any but the rarest circumstances. *See* Cates & Grimes at 161; Diggory at 321-24, 331. Hysterectomy leaves the woman sterile and has the potential to result in blood clots, severe infection, bleeding, or even death. ACOG, Patient Education Pamphlet, *Gynecologic Problems: Understanding Hysterectomy* (1995).

SUMMARY OF ARGUMENT

The Act—and others like it enacted throughout the country—is so hopelessly vague that the physicians subject to its terms cannot know what it prohibits. Reasonably read, it bans virtually all abortions in Nebraska, imperiling the public health by deterring physicians from providing their patients with medically appropriate and necessary care and imposing an unconstitutional burden on a woman's right to terminate her pregnancy.

Even if read to ban only intact D&X procedures, the Act cannot stand because it precludes some Nebraska women from obtaining the most medically appropriate abortion procedure for their particular health circumstances, and it thwarts medical advancement. The Act also lacks constitutionally compelled exceptions to protect women's health and lives.

ARGUMENT

I. THE ACT IS UNCONSTITUTIONALLY VAGUE.

Nebraska's ban on "partial-birth abortion" is hopelessly vague and therefore violates the due process rights of Dr. Carhart and his patients. *See, e.g., Colautti v. Frank-*

lin, 439 U.S. 379, 391 (1979). The Act's imprecise terms make it impossible for Dr. Carhart and similarly situated physicians to know which abortion procedures fall within the statutory ban. Contrary to the State's assertion that "no reasonable person" could interpret the Act as applying to D&E in addition to D&X (Brief of Petitioners ("Pet. Br.") 15), four reasonable federal judges —the District Court and the unanimous Court of Appeals—determined that the Act *unambiguously* bans D&E. *Carhart*, 11 F. Supp. 2d at 1120-21; 192 F.3d at 1146. At the very least, therefore, the Act is impermissibly vague because persons "of common intelligence must necessarily guess at its meaning and differ as to its application." *Smith v. Goguen*, 415 U.S. 566, 572 n.8 (1974) (citations omitted).

A. The Terms of the Act Are Hopelessly Ambiguous.

Neither the term "partial-birth abortion" nor the words used to define it provide meaningful guidance to physicians who must comply with the Act under the threat of felony prosecution and forfeiture of their medical licenses. The Act conditions liability on the performance of an abortion in which the physician "partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery." Neb. Rev. Stat. § 28-326(9). The Act then defines the phrase "partially delivers vaginally a living unborn child before killing the unborn child" to mean "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." *Id.*

This definition, however, could easily encompass virtually every safe and common abortion procedure. The phrase "partially delivers vaginally," for example, applies both when the physician partially delivers an intact fetus

into the vagina and when the physician delivers a portion of the fetus that is severed from the remainder, *see, e.g.*, *Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998), because "deliver" is a medical term of art meaning to remove the fetus, the placenta, or part of the fetus from the uterus.

The phrase "substantial portion" introduces still more vagueness. As the District Court properly found, based on the testimony of "[*e*]*very* doctor who testified," this term "could be interpreted in vastly different ways by fair-minded people." *Carhart*, 11 F. Supp. 2d at 1131 (emphasis added). Dr. Carhart understood "substantial portion" to refer to "any identifiable part of the fetus," including an extremity or a portion of the skull. *Id.* at 1118. Dr. Stubblefield testified that he had no idea how much of a fetus was a "substantial portion." *Id.* As for the State's experts, while Dr. Riegel surmised that "substantial portion . . . probably [referred to] over 50%" of the fetus, he readily conceded that "[i]t's a vague term." *Id.* Likewise, while Dr. Boehm interpreted the phrase as referring to "more than a hand or a leg," he acknowledged that "some people might consider a hand or a leg to be a substantial portion," and noted that his "own personal view" would not necessarily match that of "someone who wants to prosecute this letter of the law." *Id.* at 1119. As the District Court recognized, that is precisely why the statute is impermissibly vague. *Id.* at 1132.[18]

Finally, the Act's use of the phrase "living unborn child" further muddies the waters. "It is not clear whether 'living [unborn child]' refers only to an intact fetus with

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[18] *See also Richmond Med. Ctr. for Women v. Gilmore*, 183 F.3d 303, 305-06 (4th Cir. 1998) (Murnaghan, J., dissenting from order denying motion to vacate stay) (" 'substantial portion' [could] mean 'a portion of the trunk,' one-third of the fetus by volume, 'well into the thorax,' twenty-five percent, thirty-five percent, or a portion that is 'not insubstantial' "); *Rhode Island Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 311 (D.R.I. 1999).

a heartbeat or some other form of 'life,' or to a disarticulated fetus with a heartbeat or some other sign of 'life.'" *Miller*, 30 F. Supp. 2d at 1165. The fact that the moment at which fetal demise occurs is "'extremely variable,'" *Carhart*, 11 F. Supp. 2d at 1118 (quoting testimony of Dr. Hodgson), further compromises a physician's ability to conform his or her conduct to the requirements of the Act.

B. The Act Potentially Reaches All Safe and Common Abortion Procedures and Is Not Readily Susceptible to the State's Proffered Narrowing Constructions.

The upshot of the Act's profound ambiguity is that D&E and other safe and common abortion procedures appear to fit within the statutory ban. The ban contains three essential elements: A physician must (1) deliberately and intentionally deliver into the vagina a living fetus or a substantial portion thereof (2) for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus (3) before completing the delivery. *See* Neb. Rev. Stat. § 28-326(9). These elements cannot be confined to the D&X procedure, as the State claims.

1. *The Act Reaches D&E and Other Safe and Common Abortion Procedures.*

As both the District Court and Court of Appeals recognized, the Act, reasonably interpreted, applies to D&E abortions. *See Carhart*, 11 F. Supp. 2d at 1128; 192 F.3d at 1150. In a D&E, as in any abortion procedure (other than a hysterotomy or a hysterectomy), the physician deliberately and intentionally "delivers" the (usually living) fetus or "a substantial portion thereof"—such as an arm or leg, *see Carhart*, 192 F.3d at 1150—into the vagina. *See Methods of Midtrimester Abortion; see also Planned Parenthood v. Woods*, 982 F. Supp. 1369, 1372 (D. Ariz. 1997). The physician generally delivers a presenting part of an intact fetus through the cervical os *before* any disarticulation occurs.[19]

D&Es also satisfy the second element of the statutory ban because the physician delivers a "substantial portion" of the fetus "for the purpose of performing a procedure that the physician knows will kill the fetus and does kill the fetus." By its nature, a D&E, like any abortion, is a procedure that the physician knows will kill the fetus and that contains intermediate steps that do kill the fetus. Thus, having delivered a "substantial portion" of a living fetus, the physician performing a D&E will then cause the death of the fetus—by disarticulating it, for example, or by collapsing its skull. A physician performing a D&E invariably satisfies the third element of the ban by then "completing the delivery."[20] Therefore, as the District Court and Court of Appeals held, D&E involves each

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[19] *See Carhart*, 11 F. Supp. 2d at 1104 ("the dismemberment occurs after [Dr. Carhart] pull[s] a part of the fetus through the cervix"); *id.* at 1128 & n.42; *Carhart*, 192 F.3d at 1147. In fact, disarticulation may not occur at all. When the physician pulls a substantial portion of the fetus through the cervical os, the fetus usually disarticulates as a result of traction at the cervix, but sometimes it does not. *See Carhart*, 11 F. Supp. 2d at 1107 & n.12. Indeed, it is sometimes predictable—given the amount of cervical dilatation and the position and gestational age of the fetus—that no disarticulation will occur. Thus, a physician doing a D&E may intentionally perform a procedure indistinguishable from a D&X. Ignoring this reality of abortion practice, the State proffers the mistaken theory that a bright line separates D&E from D&X. (*See* Pet. Br. 15-18.)

[20] The District Court found that "the fetus is 'invariably' alive" when Dr. Carhart begins performing a D&E, and Dr. Carhart "has observed fetal heart activity with 'extensive parts of the fetus removed.'" *Carhart*, 11 F. Supp. 2d at 1105. And while the moment at which fetal demise occurs during the performance of the D&E varies, *id.* at 1118, fetal demise generally occurs before the physician completes the delivery of the fetus. *See Carhart*, 192 F.3d at 1150. Dr. Carhart's D&E practice is fully consistent with the procedure described in medical texts. *See* CLINICIAN'S GUIDE at 135-37; Stubblefield at 1043.

of the required elements of a "partial-birth abortion." *Carhart*, 11 F. Supp. 2d at 1128-29; 192 F.3d at 1150.[21]

2. *Nothing in the Act's Text or Legislative History Supports the Limiting Constructions Advanced by the State and Its* Amici.

A court cannot reshape the Nebraska ban into something that applies only to D&X in order to save it, because the Act is not " 'readily susceptible' to such a construction." *Reno v. ACLU*, 521 U.S. 844, 884 (1997) (quoting *Virginia v. American Booksellers Ass'n*, 484 U.S. 383, 397 (1988)). A statute is not "readily susceptible" to a narrowing construction unless its "text or other source of [legislative] intent identifie[s] a clear line" for a court to draw. *Reno*, 521 U.S. at 884. As was true of the statute at issue in *Reno*, the Nebraska ban has "many ambiguities," *id.* at 870, and thus "provides no guidance whatever for limiting its coverage." *Id.* at 884.[22]

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[21] The Act's text also encompasses some induction and vacuum aspiration procedures. Inductions may entail partial delivery of a living fetus because "a portion of the fetus may come through the cervical os and into the vaginal cavity while the fetal heart is still beating." *Woods*, 982 F. Supp. at 1872; *see also Hope Clinic*, 995 F. Supp. at 857. In some inductions, such as those in which the fetal head becomes lodged in the woman's cervix or the umbilical cord becomes entangled, the physician takes steps after partial delivery that he or she knows will cause the death of the (then still-living) fetus before completion of the delivery. *See Hope Clinic*, 995 F. Supp. at 852. Likewise, in a vacuum aspiration procedure, a substantial portion of a living fetus—either intact or disarticulated—will be delivered into the cannula in the vagina. *See Carhart*, 11 F. Supp. 2d at 1103. The separation of the fetus from the placenta or disarticulation will cause its death shortly after it is brought into the vagina and before completion of the delivery. *See id.* at 1110. In these circumstances, the physician apparently will have performed a "partial-birth abortion." *See, e.g., Miller*, 30 F. Supp. 2d at 1165.

[22] *See American Booksellers*, 484 U.S. at 397 (court "will not rewrite a . . . law to conform it to constitutional requirements"). The notion that Nebraska's or any other "partial-birth abortion" ban applies only to the delivery of an "intact" fetus, *see, e.g., Richmond Med. Ctr. for Women v. Gilmore*, 144 F.3d 326, 328 (4th Cir. 1998) (Luttig, J., as single Circuit Judge), is without basis. Neither the Nebraska Act nor any similar legislation includes that term. In any event, as shown above (Part I.B.1, *supra*), the Act would still reach D&Es even if read to apply only to the delivery of a substantial portion of an *intact* fetus: In Dr. Carhart's practice and in general, D&Es regularly involve delivery of a substantial part of an intact living fetus into the vagina before any disarticulation occurs.

Contrary to the State's assertion (*see* Pet. Br. 27-28), the Act's "scienter" requirement does not create a safe harbor for D&E. Under Nebraska law, a person intends the natural and probable consequences of his actions. *See, e.g., State v. McDaniels*, 16 N.W.2d 164, 168 (Neb. 1944). It is a natural and probable consequence of performing a D&E that the physician will deliver a substantial portion of an intact fetus and then cause its death by disarticulating it or collapsing its skull. The physician will thus "deliberately and intentionally" have violated the Act.[23]

The State further distorts the Act in claiming that its text limits the ban to D&X abortions by requiring that the physician deliver a substantial portion of the fetus into the vagina for the purpose of performing a "*separate*, death-causing procedure." (Pet. Br. 14 (emphasis added).) This phrase appears nowhere in the Act. Contrary to the State's assertion that the "procedure" mentioned in the second sentence of the Act (the physician must perform "a procedure that [he] knows will kill the unborn child") must be "separate and distinct" from the "procedure" mentioned in the first sentence (*see id.* at 17), the word "procedure" appears to refer to the same thing—an abortion—in each sentence. *See Gustafson v. Alloyd Co.*, 513 U.S. 561, 570 (1995) ("identical words used in different

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[23] *See Carhart*, 11 F. Supp. 2d at 1129 ("a surgeon performing a routine D&E deliberately intends to do exactly what defendants admit is prohibited"); *see also Carhart*, 192 F.3d at 1150.

parts of the same act are intended to have the same meaning") (internal quotation marks and citation omitted).[24]

Even if the Act could be rewritten to include "separate" and "death-causing" before "procedure" in the second sentence of the Act, that construction would only compound the vagueness of the ban. There is no rational way to distinguish the "death-causing" portion of a D&X (the use of an instrument to decompress the fetal skull) from the "death-causing" portion of a non-intact D&E (the use of an instrument to disarticulate the fetus or collapse its skull, as is often necessary in a non-intact D&E). If the "death-causing" portion of the D&X is an independent "procedure," so too is the "death-causing" portion of the D&E; in each case the physician performs a distinct act that kills the fetus before completing the delivery.[25]

[24] Nor is there any basis for the State's assertion that the Act focuses on "*where* the killing act occurs." (Pet. Br. 17 (emphasis added).) Indeed, contrary to the State's suggestion that fetal death must occur in the vagina to come within the ban (*id.*), the fact that only a "substantial portion" of the fetus need enter the vagina —rather than the whole or even the bulk of the fetus—demonstrates that fetal death can just as readily occur in the uterus during a banned procedure (to the extent that it makes any sense at all to say death occurs either in the uterus or the vagina when a fetus is in both places at once). Even with a D&X, which the State asserts to be the sole object of the ban, fetal death does not "occur" in the vagina, because the decompression of the fetal skull—what the State identifies as the "death-causing" act (*id.* at 18)—takes place *in the uterus*.

[25] Some induction and vacuum aspiration abortions also appear to be covered by the Act even if a requirement that the physician perform a separate, death-producing act is read into the statute. If the fetal head becomes lodged at the cervix or the umbilical cord becomes entangled during induction, the physician may be required to take a step that causes fetal demise, thus bringing the procedure within the Act's ban. *See, e.g., Planned Parenthood v. Verniero*, 41 F. Supp. 2d 478, 485 (D.N.J. 1988); *Hope Clinic*, 995 F. Supp. at 852. In a vacuum aspiration procedure, the cannula may become clogged by an intact fetus; the physician then must remove the suction tube, which will cause the uterus to expel its contents into the vaginal cavity and, inevitably, result in fetal demise. *See*

Conversely, if the death-producing step within a D&E were seen as indivisible from the rest of that procedure (*see* Pet. Br. 17), then there is no reason why the death-producing step in a D&X should be seen as any more distinguishable from the balance of that procedure. These opposing applications of the State's logic—neither of which is any more compelling than the other—demonstrate that the Act as the State would rewrite it is no clearer than the version that appears in the statute books.

Nor does the Act's muddled legislative history support the proffered narrowing constructions. That the leading sponsor of the bill could not articulate a meaningful (much less a limiting) definition of "substantial portion"—and indeed opined that delivery of a foot *would* be covered by the Act—vividly illustrates the Act's vagueness. *See Carhart*, 11 F. Supp. 2d at 1131. Moreover, if the legislature really had intended to ban D&X but not D&E generally, it easily could have included some language to that effect in the Act. Indeed, the thrust of the *amici curiae* brief filed by medical professionals supporting the State is that D&X is widely recognized as a distinct medical procedure. *See* Brief of Association of American Physicians and Surgeons, *et al.* ("AAPS Br.") 5-12. The purported distinctness of the D&X procedure only underscores the significance of the State's failure to make any reference to it in the Act, whether by name or by reference to its well-established components.[26] Because the legislative history at best sends "inconsistent signals as to where the new line

Carhart, 11 F. Supp. 2d at 1108, 1110; CLINICIAN'S GUIDE at 112. This separate and deliberate act therefore would appear to violate the Act.

[26] In light of this complete failure to make reference to D&X, and the strong evidence that the ban covers D&E, the Seventh Circuit's admittedly "brute force" effort "to assimilate the statutory definitions [of "partial-birth abortion"] to the medical definition of D&X," *Hope Clinic*, 195 F.3d at 865, in this case would constitute an unreasonable departure from the text of the Act and its underlying purpose.

or lines should be drawn," accepting the State's narrowing construction would constitute "a serious invasion of the legislative domain." *Reno*, 521 U.S. at 544 (internal quotation marks and citation omitted).

II. THE ACT IMPOSES AN UNDUE BURDEN ON A WOMAN'S RIGHT TO SEEK AN ABORTION.

To the extent that the Act can be understood by physicians who perform abortions, its language, on its face, criminalizes safe and common abortion procedures used throughout pregnancy. It thus imposes an impermissible undue burden on a woman's right to terminate her pregnancy in violation of this Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). By precluding a woman, in consultation with her physician, from choosing the most appropriate abortion procedure for her particular health circumstances, the Act places a substantial—and thus unconstitutional—obstacle in the path of a woman seeking an abortion.

A. The Act Prevents Women From Obtaining the Safest and Most Common Abortion Procedures Used Before Fetal Viability.

Whether read on its face or with the linguistic glosses urged by the State and the *amici* supporting it, the Act is so broad that it bans D&Es of all varieties, which account for more than 90% of post-first-trimester abortions performed in the United States, Koonin at 41 (Table 18), and 100% of Dr. Carhart's second-trimester practice, *Carhart*, 11 F. Supp. 2d at 1108-09. Because Dr. Carhart is the only provider of elective abortions after 16 weeks LMP in Nebraska, *id.* at 1102, D&Es account for nearly all abortions in the state performed between 16 and approximately 22 weeks LMP. Plainly, as the State implicitly concedes (Pet. Br. 23-28), a ban on D&Es constitutes an undue burden. *Cf. Planned Parenthood v. Danforth*, 428 U.S. 52, 79 (1976) (holding unconstitutional a ban on intra-uterine saline instillation, then the most common method of post-first-trimester abortion).[27]

Where, as here, the ban could prohibit not only D&Es, but also vacuum aspiration and induction procedures, *see* Part I.B.2, *supra*, the burden imposed by the Act is even more clearly undue. Because vacuum aspiration, induction, and D&E together account for more than 99% of abortions performed in Nebraska and in the United States, *see* Koonin at 29-30, 41 (Tables 8 & 18), such a ban is nearly absolute and unquestionably unconstitutional.

B. Even if Limited to the D&X Procedure, the Act Creates an Undue Burden Because It Unconstitutionally Forces Women From Safer to Riskier Abortion Procedures.

Even if the Act were somehow construed to proscribe only D&X, it would not pass constitutional muster. The unbroken tie that binds this Court's abortion cases is the preeminence accorded to women's health, which derives from the inescapable fact that pregnancy is fraught with health risks—including a risk of death, *see* Stubblefield at 1033—that the woman alone must bear. *See Casey*, 505 U.S. at 852. Thus, *Danforth* invalidated a ban on saline instillation abortions (which at the time left physicians with few alternatives other than hysterotomy and hysterectomy)

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[27] Forcing Dr. Carhart in all cases either to modify his current, safe D&E technique to avoid the reach of the Act by causing fetal demise *in utero* or to resort to induction abortions, a procedure that he does not now perform, would impose unacceptable health risks on his patients. *See Carhart*, 11 F. Supp. 2d at 1105-07; *see also* Stubblefield at 1046. Medical texts indicate that induction abortions are generally unavailable until 16 weeks LMP. *See* PREGNANCY LOSS at 59; *Methods of Midtrimester Abortion* at 3. The delay entailed in an across-the-board switch to induction would alone significantly and needlessly increase the health risks associated with the abortion. *See* Lawson at 1367 (Table II) (risks associated with abortion increase as gestation advances). Moreover, inductions are absolutely contraindicated for some women and relatively contraindicated for others. *See* note 16, *supra*.

because "as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 78-79. *Colautti* again underscored the primacy of women's health by holding that a restriction on a physician's choice of abortion method that does not "clearly specify . . . that the woman's life and health must always prevail over the fetus' life and health when they conflict" raises "[s]erious ethical and constitutional difficulties." 439 U.S. at 400. And *Thornburgh* made clear that the state may not regulate abortion, including restricting a physician's choice of method, if it "fail[s] to require that maternal health be the physician's paramount consideration." *Thornburgh v. ACOG*, 476 U.S. 747, 768-69 (1986).

Casey did nothing to alter the weight this Court has always placed on maternal health in its analysis. Rather, *Casey* reaffirmed *Roe's* essential holding that—both pre- and post-viability—a state may not "interfere with a woman's choice to undergo an abortion procedure if continuing a pregnancy would constitute a threat to her health." 505 U.S. at 880, 846. A corollary to this holding is the principle that the state may not force a woman to terminate a pregnancy by a method less medically appropriate for her and may not deprive a woman of her right to choose among medically sound alternative methods of pregnancy termination. This, however, is precisely what the Act requires—even if read to ban only D&X.

1. *D&X Is a Safe Procedure, Within the Standard of Care, That Will Be the Most Medically Appropriate Procedure for Some Patients.*

Central to women's ability to protect their health interests is the ability of their physicians to exercise appropriate medical judgment. *See City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 427 (1982). "The choice of an appropriate abortion technique . . . is a complex medical judgment . . . ." *Colautti*, 439 U.S. at 401. On the basis of various factors—including the patient's

overall medical condition; the gestational age, size, and presentation of the fetus; the extent of dilatation of the cervix; the existence of fetal abnormalities; and a patient's desire, for example, to avoid prolonged labor and hospitalization—a physician, in consultation with his or her patient, chooses the most appropriate and safest abortion procedure for that particular patient at the time. *See* KENNETH E. NISWANDER & ARTHUR T. EVANS, MANUAL OF OBSTETRICS 15 (5th ed. 1996). The risk of a particular abortion procedure varies in every case, depending on the individual woman's health, the skill of the physician performing the procedure, the medical facilities available, and how the selected procedure proceeds on a given day. *See* CLINICIAN'S GUIDE at 125-26.

Depending on the physician's skill and experience, the D&X procedure can be the most appropriate abortion procedure for some women in some circumstances.[28] D&X presents a variety of potential safety advantages over other abortion procedures used during the same gestational period. Compared to D&Es involving dismemberment, D&X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments and reduces the presence of sharp fetal bone fragments that can injure the uterus and cervix.[29] There is also considerable evi-

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[28] For example, as the District Court found, there are at least 10 to 20 Nebraska women each year for whom a D&X is the most appropriate procedure. *See Carhart*, 11 F. Supp. 2d at 1106, 1121-22, 1127.

[29] *See* CLINICIAN'S GUIDE at 135 ("When possible, intact delivery in pregnancies over 18 weeks reduces the number of instrument passes necessary for extraction."); *id.* at 136 ("The aim of intact D&E is to minimize instrumentation within the uterine cavity. . . ."). The testimony of experts on abortion practice overwhelmingly confirms this view. *See Evans*, 977 F. Supp. at 1296 (recounting testimony of six medical experts); *Voinovich*, 911 F. Supp. at 1069 (D&X "causes less trauma to the maternal tissues (by avoiding the break up of bones, and the possible laceration caused by their raw

dence that D&X reduces the risk of retained fetal tissue, a serious abortion complication that can cause maternal death, and that D&X reduces the incidence of a "free-floating" fetal head that can be difficult for a physician to grasp and remove and can thus cause maternal injury.[30] That D&X procedures usually take less time than other abortion methods used at a comparable stage of pregnancy can also have health advantages. The shorter the procedure, the less blood loss, trauma, and exposure to anesthesia.[31] The intuitive safety advantages of intact D&E are supported by clinical experience. *See* CLINICIAN'S GUIDE at 137-38.

Especially for women with particular health conditions, there is medical evidence that D&X may be safer than available alternatives. A select panel convened by ACOG concluded that D&X may be "the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman."[32] D&X may also be

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edges)"); *see also Carhart*, 11 F. Supp. 2d at 1107; *Whitehouse*, 66 F. Supp. 2d at 314; *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441, 455, 490 (E.D. Va. 1999); *Verniero*, 41 F. Supp. 2d at 485; *Miller*, 30 F. Supp. 2d at 1161; *Hope Clinic*, 995 F. Supp. at 851.

30 *See Carhart*, 11 F. Supp. 2d at 1107, 1123. Practitioners and medical experts confirm these potential advantages. *See Evans*, 977 F. Supp. at 1296; *Hope Clinic*, 995 F. Supp. at 851.

31 *See Richmond Med. Ctr.*, 55 F. Supp. 2d at 491; *Hope Clinic*, 995 F. Supp. at 852; *Voinovich*, 911 F. Supp. at 1069.

32 *ACOG Statement* at 2; *see also Voinovich*, 911 F. Supp. at 1067 (D&X may be most medically appropriate for women with prior uterine scar); *Evans*, 977 F. Supp. at 1296 (D&X is especially appropriate for women for whom induction is contraindicated). That ACOG "could identify no circumstances under which this procedure . . . would be the *only* option to save the life or preserve the health of the woman," *see ACOG Statement* at 2, is in no way inconsistent with the proposition that D&X may be the best or most appropriate procedure in certain circumstances. A single abortion procedure will virtually never be the *only* option to save the life or preserve the health of a woman, but it may be the *best* option.

the most appropriate abortion method in the presence of certain fetal indications. For example, D&X "may be especially useful in the presence of fetal abnormalities, such as hydrocephalus" because it entails reducing the size of the fetal skull "to allow a smaller diameter to pass through the cervix, thus reducing risk of cervical injury." David A. Grimes, *The Continuing Need for Late Abortions*, 280 JAMA 747, 748 (Aug. 26, 1998). In addition, "intactness allows unhampered evaluation of structural abnormalities" in the fetus and can thus aid in diagnosing fetal anomalies. CLINICIAN'S GUIDE at 136. Finally, an intact fetus can "aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding." *Id.*[33]

No reliable medical evidence supports the claims of the State's *amici* physicians that D&X endangers maternal health. These doctors claim (AAPS Br. 21-22) that the amount of cervical dilatation involved in D&X procedures can cause cervical incompetence. Many D&E procedures, however, involve similar amounts of dilatation—sometimes over a several-day period, *see* CLINICIAN'S GUIDE at 128; GLICK at 49—and of course childbirth involves even greater cervical dilatation. Their concern about the risks posed by internal podalic version, in which the physician repositions the fetus into a footling breech (AAPS Br. 22), is similiarly misplaced. Dr. Carhart "does not perform instrumental conversion of the fetus . . . but [rather] removes the fetus headfirst or feet first, depending on how the fetus is positioned." *Carhart*, 11 F. Supp. 2d at 1105.[34] Moreover, some clinicians recommend reposition-

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33 Some physicians also believe intact D&E is an easier procedure for physicians to master because it involves techniques that are more familiar to physicians than those involved in non-intact D&E. *See generally NAF Bibliography*; CLINICIAN'S GUIDE at 136.

34 There is nothing "self-contradictory" (AAPS Br. 16-17) about Dr. Carhart's belief that intact extraction is safer than dismemberment on the one hand, and his unwillingness to convert the fetus in

ing the fetus in some D&Es depending on how the fetus initially presents. *See* CLINICIAN'S GUIDE at 135. The "blind" procedure (piercing the fetal skull) that the *amici* physicians warn is so dangerous in a D&X (AAPS Br. 22-23) is arguably less blind than the continued use of sharp instruments in the uterine cavity that characterizes D&Es.[35] The State's (and its *amici* physicians') attempt to justify a ban on D&X as a protection of maternal health is clearly pretextual: The Act permits precisely the same procedure (with the same alleged risks to the woman) so long as the physician effects fetal demise *in utero* before any portion of the fetus is vaginally delivered.[36]

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order to perform a D&X on the other hand. First, the charge of inconsistency fails to recognize that Dr. Carhart performs intact D&Es, and thus realizes the safety advantages of intact extraction, when the fetus presents head-down, without the need for conversion. *See Carhart*, 11 F. Supp. 2d at 1105. Second, it is perfectly consistent for Dr. Carhart to conclude, given his assessment of his own skills and the relative risks involved, that the potential safety advantages of D&X are reduced (and even outweighed) when he must convert the fetus from a transverse or compound presentation. That conclusion, however, in no way undermines the determination that D&X is the safest procedure for Dr. Carhart's patients *when he can perform it*. Likewise, the relative infrequency of D&X in Dr. Car' .t's practice in no way refutes its safety advantages or argues against attempting it where appropriate.

[35] *See* CLINICIAN'S GUIDE at 133. Uterine perforation, which can require a bowel resection, colostomy, or hysterectomy, is the most serious complication of D&E and can be fatal. *See, e.g.*, Edward Trott et al., *Major Complications Associated with Termination of a Second Trimester Pregnancy: A Case Report*, 67 DEL. MED. J. 294, 296 (1995).

[36] The State's and its *amici* physicians' objection to D&X on the ground that it "blurs the line . . . between abortion and infanticide," by using obstetrical techniques to "perform[] an act quite contrary to the obstetrical role" (AAPS Br. 27; *see also* Pet. Br. 29), is equally misplaced. All abortion procedures use obstetrical techniques. Induction abortions in particular contain almost every element of delivery at term. *See Induction of Labor*. There is nothing unethical or medically inappropriate in employing obstetrical and gynecological techniques to terminate pregnancy in the

2. *A Ban Solely on D&X Cannot Withstand Constitutional Scrutiny.*

This Court has invalidated choice-of-method statutes that remove physician discretion and force women to resort to abortion procedures that are less safe or less appropriate for their particular health circumstances. *See Danforth*, 428 U.S. at 75-79; *Thornburgh*, 476 U.S. at 766-69. Underlying these holdings is the recognition that a constitutionally impermissible threat to women's health always results when the state removes a safe medical procedure from the physician's array of options. That other safe abortion procedures may remain available (Pet. Br. 33) does not eliminate the constitutional problem. Because the banned procedure will always be the safest for some (if not most) women, an absolute prohibition on a safe method of abortion will impermissibly increase the health risks of abortion for some women in some circumstances. The unbroken emphasis on maternal health in this Court's abortion jurisprudence precludes the state from restricting abortion in a manner that imposes such increased health risks. *See Casey*, 505 U.S. at 880.

The suggestion that a state may ban a safe abortion procedure so long as that procedure is not needed by a large number of women, *see Hope Clinic*, 195 F.3d at 871-74, betrays a misunderstanding of this Court's precedents. Rather, from this Court's command that women's health remain "paramount," *Thornburgh*, 476 U.S. at 769, and that every abortion restriction contain an exception to permit a woman to obtain an immediate abortion if continuing her pregnancy would constitute a threat to her health, *Casey*, 505 U.S. at 846, 880, it follows that a safe procedure that is within the standard of care must remain available for *each and every* woman for whom that procedure would be the most appropriate.

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manner safest for the patient and in keeping with the physician's role as a provider of comprehensive reproductive health services.

As the District Court found, even if the Act affected only the 10 to 20 women per year for whom Dr. Carhart performs a D&X, it would violate the constitutional rights of these women. *See Carhart*, 11 F. Supp. 2d at 1121-22, 1127; *see also Hope Clinic*, 195 F.3d at 884 (Posner, C.J., dissenting) ("It is slight consolation to be told that while the state has forbidden the optimal treatment of your medical problem, that problem happily is rare."). Banning a procedure that may be the most appropriate even for a small fraction of women impermissibly endangers their health.[37]

III. THE ACT THREATENS WOMEN'S HEALTH BY HINDERING MEDICAL ADVANCEMENT.

The Act also endangers women's health by impeding physicians from developing new, and potentially safer, surgical techniques. This Court has long recognized that "present medical knowledge" changes, *see Akron*, 462 U.S. at 437, and that bans on abortion methods threaten to stymie medical advancement. Thus, in *Danforth*, the Court invalidated a broad ban on saline instillation because it threatened to preclude "methods that may be developed in the future and that may prove highly effective and completely safe." 428 U.S. at 78. The Act at

[37] Consider, for example, a ban on hysterotomies. Despite data indicating that hysterotomies are significantly more dangerous than every common method of abortion except hysterectomy, *see* Lawson at 1367 (Table II), a small number of abortions continue to be performed by hysterotomy each year because physicians resort to this procedure in specific and serious health situations. *See* CLINICIAN'S GUIDE at 126 (hysterotomy indicated for "life threatening medical crises such as unremitting hemorrhage associated with placenta accreta, massive disseminated intravascular coagulation (DIC), or severe forms of preeclampsia"); Koonin at 41 (Table 18) (36 reported abortions in 1996 were performed by hysterotomy or hysterectomy). It would be medically inappropriate to ban hysterotomy because, for a small number of women each year, that procedure was the safest in their particular health circumstances. A ban on D&X—even if D&X is the safest option for only a handful of women—is similarly medically inappropriate and unconstitutional.

issue here also fails to leave room for medical evolution and thus violates a guiding principle of this Court's prior abortion rulings.

The most common abortion procedures used today were all developed by physicians seeking safer procedures. For example, vacuum aspiration developed as a safer alternative to dilatation and curettage ("D&C"), which was slower, less thorough, and caused many more complications. *See* Pak at 54. Although vacuum methods for uterine evacuation were known as early as 1872, *see* CLINICIAN'S GUIDE at 107, it was only after abortion became legal nationwide in 1973 that physicians were free to develop the vacuum aspiration technique to the point where it has replaced D&C as the preferred method of first-trimester abortion.[38]

Likewise, D&E was developed in the early 1970s in response to the shortcomings of inductions (*see* Part B.2.b., *supra*) and the lack of an effective procedure between 12 and 16 weeks LMP, when inductions often cannot reliably be performed. For several years, physicians labored alone to develop a surgical procedure; finally, in 1975, D&E techniques began to be shared among physicians. D&E has become the most common and safest post-first-trimester abortion method in large part due to the ingenuity of physicians looking for better options for their patients. *See* GLICK at 46-48; *see also Akron*, 462 U.S. at 435-37. One of the reasons D&E safety has itself improved so markedly is that physicians have experimented with slightly varying techniques in performing it, and have taught the different techniques to colleagues. *See, e.g.*, GLICK at 47.

[38] *See* CLINICIAN'S GUIDE at 107-08; Jane E. Hodgson, *Abortion by Vacuum Aspirator*, *in* ABORTION AND STERILIZATION: MEDICAL AND SOCIAL ASPECTS 225, 225-26, 234-39 (Jane E. Hodgson ed., 1981); Pak at 54.

The variation of D&E techniques among physicians arises from innovation during surgical procedures, either in response to some unforeseen circumstance or as a result of an observation made by the physician in the course of the procedure. D&X thus arose as a minor variant of D&E. *See, e.g.*, CLINICIAN'S GUIDE at 136. As discussed above, D&X may offer a variety of safety advantages over D&E and induction methods. Permitted to evolve, D&X could well turn out to improve abortion safety markedly or lead to the discovery of one or more other techniques that would effect such improvement. Nebraska's "partial-birth abortion" ban and others like it, if permitted to stand, would ensure that this potential will never be realized.[39]

IV. THE ACT LACKS CONSTITUTIONALLY COMPELLED EXCEPTIONS TO PROTECT A WOMAN'S HEALTH AND TO SAVE HER LIFE.

The Act also is unconstitutional because it fails to exclude from its ban situations in which a woman's health or life is at risk. *Casey* made clear that any regulation of abortion must contain an exception "for pregnancies which endanger the woman's life or health." *Casey*, 505 U.S. at 846. In contravention of this command, the Act lacks any health exception whatsoever, and contains a constitutionally inadequate life exception.

As *Casey* recognized, pregnancy can often place a woman's life or health in jeopardy. In such circumstances, a physician must be permitted not only to provide an abortion, but also to use the method he or she determines to be most medically appropriate: In a medical emergency requiring quick response to rapidly changing circumstances, permitting a physician the discretion to

[39] There will be no opportunity for the safety and benefits of D&X to be recognized in peer-reviewed studies—the lack of which both the State and its *amici* use to condemn the technique (Pet. Br. 39; AAPS Br. 14-15)—if there is a criminal prohibition on its use.

use the full range of treatment options is particularly crucial. Given the Act's breadth, its omission of a health exception is clearly unconstitutional. Because D&X is the most medically appropriate abortion method in some situations, however, the lack of a health exception would condemn the Act even if it could be construed to target only D&X. The Act would force a woman whose health is threatened by pregnancy to choose between undergoing an abortion procedure more dangerous to her health than D&X and continuing her pregnancy in the face of potentially serious health risks. This *Casey* clearly forbids. 505 U.S. at 846, 879-80.

The State's suggestion that the absence of a health exception is constitutionally permissible because such an exception is not "necessary in all circumstances or even in a large fraction of circumstances" (Pet. Br. 31) misconstrues this Court's precedent. *Casey* held that the State can *never* interfere with "*a* woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880 (emphasis added). The requirement of a health exception continues throughout pregnancy and applies even after fetal viability when the state is otherwise free to ban abortion. *Id.* at 877-78. There is no need to show that the health of "a large fraction" of women needing an abortion (or specifically, a D&X) will be jeopardized by the Act. The "large fraction" test simply does not apply where a woman's health is at risk. If, as here, an abortion restriction will endanger the health of *any* woman, the restriction must contain a health exception.

The Act's narrow and wholly inadequate life exception also contravenes *Casey* and jeopardizes women's health. The Act permits a physician to perform a "partial-birth abortion" only if the banned procedure is "necessary to save the life of the mother." Neb. Rev. Stat. § 28-328(1). If a hysterotomy or hysterectomy would save a woman's

life, the Act requires the physician to resort to those procedures even though they present far greater risks to the woman's health and future fertility than any of the banned procedures. The Act's life exception is further deficient because it is limited to situations in which the woman's life is threatened by a "physical disorder, physical illness, or physical injury." *Id.* Such a limitation violates *Casey*'s command that abortion restrictions contain an exception for *any* threat to a woman's life. *See Casey*, 505 U.S. at 879. Finally, the Act does not clearly permit physicians to rely on their own best medical judgment in determining whether a banned procedure is necessary to save a woman's life. *See Colautti*, 439 U.S. at 395-96, 401. Even physicians who act in good faith in a medical emergency risk imprisonment and loss of license if their decisions are later second-guessed. The Act therefore hinders a physician's ability to provide his or her patients with the best medical care.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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